AUTHORIZATION TO RELEASE HOSPITAL RECORD INFORMATION

Authorization with an original signature* of an officer of the hospital is required to release hospital confidential data to persons not associated with the hospital.

Please release hospital confidential data to:

NAME:_____

ADDRESS:_____

PHONE:_____

SIGNATURE:_____

Officer authorizing release of hospital confidential data:

NAME:_____

TITLE:_____

HOSPITAL:_____

ADDRESS:_____

PHONE:_____

SIGNATURE:_____

*A FAXed document does not satisfy the criteria for an original signature.

Please complete, sign, and mail to:

Department of Health Services
Disproportionate Share Hospital Unit
1501 Capitol Avenue, MS 4600
P.O. Box 942732
Sacramento, CA 94234-7320